Submission to the Senate Standing Committee on Economics: Inquiry into the Scrutiny of Financial Advice

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1 Introduction

The Public Interest Advocacy Centre (**PIAC**) is aware that people living with, or who have experienced mental illness in the past, find it substantially more difficult than others to access many forms of insurance, including life insurance.

Given that one in five Australians will be affected by mental illness in any 12-month period and 45% of Australians will experience a mental illness at some time in their life,[1] it is clearly a matter of broad public interest to ensure that the insurance market is designing, pricing and offering policies, as well as assessing claims on existing polices, in a manner that is founded on robust evidence and contemporary understandings of mental illness.

Since 2012, PIAC has been providing legal advice and representation to people who have experienced discrimination, or otherwise been treated unfairly, by general and life insurance providers on the basis of a mental health condition. PIAC has identified systemic problems with industry practices that are failing to protect vulnerable consumers from unlawful disability discrimination or other forms of unlawful or unfair behaviour.

1.1 Terms of Reference

PIAC welcomes this opportunity to address the expanded terms of reference referred to the Senate Economics Reference Committee (the **Committee**) on 2 March 2016 as part of its inquiry into the Scrutiny of Financial Advice (the **Inquiry**), namely:

a. the need for further reform and improved oversight of the life insurance industry;
b. whether entities are engaging in unethical practices to avoid meeting claims;
c. whether a life insurance industry code of conduct is required;
d. the role of the Australian Securities and Investments Commission in reform and oversight of the industry; and
e. any related matters.

PIAC would also welcome the opportunity to speak with the Committee about this submission and our casework in further detail.

PIAC notes that the Inquiry's terms of reference are limited to the life insurance industry. Life insurance encompasses a variety of products that provide payment upon death or injury, including income protection insurance. Although PIAC focuses this submission accordingly, we note that many of the issues discussed apply to the general (travel) insurance industry as well.

'Life insurance' in these submissions means life, income protection, trauma and total and permanent disability insurance.

[1] Australian Bureau of Statistics (ABS), *National survey of mental health and wellbeing: summary of results, Australia*, 2007. ABS cat. no. 4326.0, available http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features12007?OpenDocument.

2 The Public Interest Advocacy Centre

PIAC is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from NSW Trade and Investment for its work on energy and water, and from Allens for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

2.1 PIAC's work on disability discrimination & insurance

PIAC has a long history of providing legal assistance and policy analysis in the area of disability discrimination. In particular, this submission builds on PIAC's previous submissions to the following Inquiries:

- Senate Legal and Constitutional Affairs Committee inquiry into the Exposure Draft of the Human Rights and Anti-discrimination Bill 2012 that reported on 21 February 2013.[2]
- Australian Law Reform Commission's inquiry into Equality, Capacity and Disability in Commonwealth Laws that reported on 24 November 2014.[3]

In 2012, Mental Health Australia (then the Mental Health Council of Australia) (**MHA**) and *beyondblue* approached PIAC detailing concerning levels of apparent unlawful discrimination on the ground of mental health in the insurance industry, in particular with regard to the provision of

[2] Public Interest Advocacy Centre, Submission No 421, Senate Legal and Constitutional Affairs Committee, *Exposure Draft of Human Rights and Anti-Discrimination Bill 2012* (21 December 2012) available http://www.piac.asn.au/publication/2013/01/aligning-pieces.

[3] Public Interest Advocacy Centre, Submission No 41, Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (20 January 2014) available http://www.piac.asn.au/publication/2014/01/equality-law-people-disability.

general (particularly, travel) and life insurance products (including income protection, trauma and total and permanent disability insurance).

Since then, PIAC has provided advice and legal representation in both State and Federal jurisdictions to over 95 individuals across the country who believe general or life insurance services providers (**life insurance providers**) have discriminated against them because of a mental health condition or purported mental health condition or avoided a policy under the *Insurance Contracts Act 1984* (Cth) (**ICA**) because of non-disclosure of a purported mental health condition.

Approximately 75% of our work has related to discrimination in the provision of, and claims relating to, life insurance products.

2.2 Systemic problems identified through PIAC's work

PIAC has observed the following systemic problems in relation to life insurance products and mental health.

1. An applicant for insurance discloses a past or current mental health condition when applying for life insurance and the insurer:

    a. **refuses** to offer insurance; or
    b. offers insurance with a **broad mental health exclusion**, in circumstances where a more limited mental health exclusion would have been reasonable; or
    c. offers insurance without a mental health exclusion but with an **unreasonably high premium**.

2. An applicant for insurance discloses **symptoms** of a mental health condition when applying for life insurance but has never been diagnosed with a mental health condition and the insurer:

    a. **imputes** a mental health condition that is not supported by the information provided in the application or by medical practitioners; and
    b. **refuses** to offer insurance, offers insurance with a broad mental health exclusion or offers insurance with a premium.

3. An applicant for insurance does not disclose a mental health history when applying for cover or to amend existing cover in circumstances where the non-disclosure is innocent or the insured had never been diagnosed with a mental health condition. When the insured later makes a claim on the policy, the insurer **purports to avoid** the policy for non-compliance with the insured's duty of disclosure under the ICA.

3 Summary of recommendations

Recommendation 1

PIAC recommends that the Insurance Council of Australia be resourced to establish a consultative body to develop and regulate a life insurance industry code of conduct. The consultative body should comprise representatives of the key stakeholders, including life insurance providers, consumers, consumer associations, Federal government and other community groups.

Recommendation 2

PIAC recommends that the proposed life insurance industry code of conduct should require insurers to:

a. *ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;*
b. *refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;*
c. *give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;*
d. *where an insurer offers insurance on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium), specify:*
    i. *how long it is intended that the exclusion/higher premium will apply to the policy.*
    ii. *the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced.*
    iii. *the process for removing or amending of the exclusion/premium;*
e. *develop, implement and maintain policies that reflect the above practices.*

Recommendation 3

A life insurance industry code of conduct should include and expand upon the training obligations set out in FSC Standard No 21 and which requires insurers to develop, implement and periodically deliver training to its officers, including call centre operators and underwriters on:

a. *mental health conditions, the spectrum on which they can occur and their treatment.*
b. *the operation and requirements of section 46 of the Disability Discrimination Act 1992 (Cth) (DDA) (the insurance exception).*
c. *communicating with people with mental illness.*

Recommendation 4

That section 46 of the DDA be amended to:

a. *require insurers to provide copies of the actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer within a reasonable time frame upon request. Wherever possible, this material should be provided to the applicant with a summary in a readily accessible and plain-language format, making reference to the specific additional risk that the applicant represents;*

b. *require insurers to provide a detailed summary that specifies the type of data that the insurer has relied on, and the relevance of that data to the decision to decline insurance coverage to the applicant, or to offer coverage on non-standard terms, where copies of the actual actuarial and statistical data relied on are not able to be provided because the material is considered to be commercial-in-confidence;*
c. *require an insurer to advise a consumer what relevant factors it considered, why it considers each of those factors to be relevant, and how those factors affected its decision in relation to an offer of insurance;*
d. *specify that 'other relevant factors' (consistent with the Australian Human Rights Commission guidelines and the decision of the Federal Court in Bassanelli):*
    i. *means all other relevant factors, and not just the factors selected for consideration by the particular insurer or other person seeking to invoke the exemption. This includes factors that reduce any risk to insurers as well as the factors that increase the risk to insurers;*
    ii. *includes the factors that are relevant to the circumstances of the individual applicant; and*
    iii. *is not exhaustive and that any other factors not listed in the DDA or AHRC guidelines may be considered relevant.*

Recommendation 5

Section 75 of the ICA should be amended to require:

a. *insurers to provide written reasons when asked by an insured, irrespective of whether the insured has made the request orally or in writing, or alternatively require insurers to state in the letter declining cover that under section 75 of the ICA an insurer must provide written reasons upon written request given to the insurer;*
b. *the written reasons provided by the insurer to explain the actuarial or statistical data that they have relied upon to decline cover to the applicant. The data cited and relied upon must address the specific disclosures made by the applicant.*

Recommendation 6

The ICA should be amended to require insurers, within 14 days of receiving an application for review in relation to a decision not to provide insurance, to offer insurance on non-standard terms, or to avoid a policy for 'non-disclosure', to specify which documents they require to conduct the review, and to require that the documents sought are relevant to the decision/review.

Recommendation 7

PIAC recommends that the proposed insurance industry code of conduct requires insurers to:

a. *provide information and undertake internal reviews within reasonable time periods.*
b. *correspond directly with an applicant or insured who made their application for insurance through an insurance broker wherever the applicant or insured so wishes.*

Recommendation 8

Parliament should reverse the amendments to section 29 of the ICA. That provision should require an insured to prove that the insurer would have offered the insured 'a' contract of insurance not 'the' specific contract of insurance that is the subject of dispute.

Recommendation 9

The proposed life insurance industry code of conduct should:

a. *require insurers to vary rather than avoid policies wherever reasonably possible;*
b. *include guidance notes providing examples of situations in which variation rather than avoidance of a policy is appropriate, including where the insured has made a claim on their policy for an illness or condition that is unrelated to the illness or condition that it is alleged was required to have been disclosed during the application process.*

Recommendation 10

Each insurer should be required to report publicly (eg, in its annual report) the number of policies that it avoided in the previous 12 months.

Recommendation 11

a. *Insurance companies should be required to report annually to the Australian Human Rights Commission the number of times they have declined to provide insurance or offered insurance on different terms on the ground of disability. This information should specify whether the insurer has relied on actuarial and statistical data in making their decision and the category of disability invoked by the exception. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.*
b. *When a matter is before the AHRC or state anti-discrimination body, insurers should be required to promptly provide to the AHRC or state anti-discrimination body the actuarial and statistical data and other relevant factors relied upon to decline coverage or refuse a claim on the ground of mental illness or another protected attribute, when requested to do so.*
c. *Insurers should be required to comply with updated insurance Industry Anti-Discrimination Guidelines that could be developed by the AHRC.*
d. *The AHRC or another statutory agency should be empowered to investigate and enforce breaches of the DDA, including the power to audit an insurer's actuarial and statistical data.*
e. *At the very least, the Australian Government should negotiate an agreement with insurers to require them to publish data on which decisions about insurance offerings based on disability are made.*

Recommendation 12

When a complaint is lodged with either FOS, the AHRC or a state anti-discrimination body, and the complaint concerns:

a. *an insurance contact that has been avoided;*
b. *application for insurance denied or accepted on non-standard terms; or*
c. *an insurance claim that has been denied because of a person's disability,*

that FOS, the AHRC or state anti-discrimination body be required to advise the complainant to seek legal advice on choice of jurisdiction and the merits of their matter before the complaint is accepted for conciliation. If the complainant is unable to obtain legal advice then FOS, the AHRC or state anti-discrimination body should provide the complainant with information regarding choice of jurisdiction before the complaint is accepted for conciliation.

4 Legislative frameworks

The systemic problems discussed in these submissions arise in the context of two legislative frameworks: state and federal anti-discrimination legislation and the *Insurance Contracts Act 1984* (Cth).

The systemic problems observed by PIAC in relation to life insurance products and mental health raise issues within both legislative frameworks.

4.1 Disability discrimination

PIAC is concerned that some of the practices of insurers that we have observed constitute unlawful disability discrimination in breach of state and federal anti-discrimination legislation and that insurers are, in some instances, knowingly engaging in unlawful disability discrimination and/or engaging in unethical practices.

For the purpose of this submission, PIAC focuses on the legislative context for unlawful disability discrimination at a federal level only. However, we note that equivalent legislative provisions exist in each state and territory and operate in substantially the same way.

4.1.1 Discrimination on the ground of mental illness

The *Disability Discrimination Act 1992* (Cth) (**DDA**) is designed to protect individuals against unlawful disability discrimination.

Section 5 of the DDA provides that a person (the discriminator) discriminates against another person (the aggrieved person) on the ground of disability if, because of the disability, the discriminator treats or proposes to treat the aggrieved person less favorably than the discriminator would treat a person without the disability in circumstances that are not materially different.

Past, present, future and imputed mental health conditions as well as mild and minor conditions, including depression and anxiety, all fall within the definition of disability set out in section 4 of the DDA.

4.1.2 The insurance exception

The DDA contains a specific exemption for life insurance providers.

Section 46 allows an insurance provider to lawfully discriminate against a person with a disability:

a. where the discrimination in based on actuarial or statistical data that is reasonable for the insurance provider to rely on; and
b. the discrimination is reasonable having regard to that data and all 'other relevant factors'.[4]

If there is no statistical or actuarial data available or reasonably obtainable to assess the risk, an insurer may justify its discrimination by relying solely on all 'other relevant factors'.

[4] Similar provisions can be found in state anti-discrimination legislation. For example, see *Anti-Discrimination Act 1977* (NSW) s 49Q; and *Equal Opportunity Act 2010* (Vic) s 47; which each provide a similar exception for insurers in the area of disability discrimination.

The exception for insurance providers within the DDA is a practical acknowledgement of the insurance industry's business model, central to which is the ability to differentiate between levels of risks, and to provide their products to a prospective insured on terms that account for those risks.

4.1.3 What is 'reasonable' actuarial and statistical data?

The DDA does not define the term 'reasonable' in the s 46 exception. However, in *QBE Travel Insurance v Bassanelli* [2004] FCA 396 (at [30]), the Federal Court of Australia held that the question of the reasonableness of the reliance on actuarial and statistical data to discriminate against a person:

> involves an objective judgment about the nature and quality of the actuarial or statistical data relied on. The actuary or statistician (or the data itself) may indicate that for whatever reason it would not be reasonable to rely upon it. It may be qualified, or be an insufficient sample for reliable use, or not be directly applicable to the particular decision. There may be other reasons why, on its face, it would not be reasonable to rely upon it. There may be actuarial or statistical data upon which it may be unreasonable to rely for other reasons external to the data being relied upon. The data may be incomplete, or out-of-date, or discredited, and the decision-maker ought, in the circumstances, to have known that.

4.1.4 What are 'other relevant factors'?

The phrase 'other relevant factors' in s 46 is not defined in the DDA. The Australian Human Rights Commission *Guidelines for Providers of Insurance and Superannuation* (Revised 2005) provides that 'other relevant factors' will include the personal circumstances of the insured, medical opinion, opinions from other professional groups, actuarial opinions and commercial judgment.[5]

4.2 *Insurance Contracts Act 1984* (Cth)

PIAC is concerned that insurers are using the provisions of the *Insurance Contract Act 1984* (Cth) to unnecessarily avoid policies for non-fraudulent non-disclosure or misrepresentation instead of electing to vary policies, in circumstances where varying the policy would still require the insurer to pay the current claim on the policy.

4.2.1 The insured's duty of disclosure

Section 21 of the ICA sets out an insured's duty to disclose to an insurer before entering into a contract for life insurance every matter that is known to the insured, being a matter that: (a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or (b) a reasonable person in the circumstances could be expected to know to be a matter so relevant.[6] 'Known' means more than suspected or believed.[7]

An insured's duty of disclosure does not require the disclosure of matters that diminish the risk, that are of common knowledge, that the insurer knows or ought to know in the course of carrying on their business, or where the insurer has waived the insured's compliance with the duty of

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5 In *QBE Travel Insurance v Bassanelli* [2004] FCA 396 the Federal Court found that an insurer must not rely solely on general assumptions about people of a particular age or sex or particular disability in deciding to refuse cover.

6 ICA s 21(1).

7 *Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd* (1998) 153 ALR 529 at 582-3; *Permanent Trustee Australia Ltd v FAI General Insurance Company Ltd (in liq)* (2003) 214 CLR 514 at 531.

disclosure.[8] An insurer will waive compliance if the insured fails to answer, or gives an obviously incomplete or irrelevant answer in an application form and the insurer does not follow up with the insured for clarification.[9]

4.2.2 Remedies available to insurers for failure to comply with the duty of disclosure

The remedies available to an insurer are set out in section 29 of the ICA. An insurer will not have a remedy under section 29 if the insurer would have entered into the contract of insurance even if the insurer had not failed to comply with their duty of disclosure.[10]

An insurer may avoid a contract of insurance at any time if the non-disclosure or misrepresentation was fraudulent,[11] or within the first three years of the contract if the non-disclosure or misrepresentation was not fraudulent.[12]

Applying to contracts for life insurance entered into, and in some cases varied, from 28 June 2014, the ICA was amended to expand the remedies available to insurers where an insured has not complied with their duty of disclosure.[13] The purpose of the amendments was largely to introduce more flexible remedies for insurers to better cater for the strong market emergence of non-traditional life insurance (ie, products that do not have a surrender value and do not provide cover on death – in other words, products such as income protection insurance, total and permanent disability insurance).[14]

Prior to the amendments, consumers had greater protection from avoidance based on innocent non-disclosures because an insurer would have needed to show that it would not have been prepared to enter into *a* contract of life insurance on *any terms* if the duty of disclosure had been complied with.[15]

4.2.3 Obligation to provide written reasons

Section 75 of the ICA sets out the available parameters for a life insured to request reasons from an insurer that has refused cover, cancelled a contract, failed to renew a contract or offered insurance on less than advantageous terms than the insurer would otherwise offer (the decision). The insured must make the request in writing.[16] The insurer is obliged to give reasons to the insured, and failure to comply incurs a civil penalty, unless:

- the insured is not the life insured (ie, where the life insured is included on another person's policy and the other person is requesting the reasons) and either: the only reason is the health of the life insured,[17] or if the health of the life insured is one reason

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8 ICA s 21(2).
9 ICA s 21(3).
10 ICA s 29(1).
11 ICA s 29(2).
12 ICA s 29(3).
13 The amending Act was the *Insurance Contract Amendment Act 2013* (Cth).
14 The reasons for the amendments to the remedies available to insurers are discussed in the Explanatory Memorandum, Insurance Contract Amendment Bill 2013 (Cth) at [1.113] – [1.119] and [2.117] – [2.122]. The Explanatory Memorandum notes that many of the amendments adopt the recommendations made by the Review Panel commissioned by the Australian Government in 2003 to review the ICA.
15 ICA s 29(3) as then applicable.
16 ICA s 75(5).
17 ICA s 75(3).

among others, the insured must not include any reference to the health of the life insured in any reasons given to the insured;[18] or

- the insurer relies on the statutory defence and can prove that compliance with the requirements to give reasons would have unreasonably put at risk the interests of the insurer or of some other person.[19]

The insurer can require the insured to nominate in writing a medical practitioner to whom the insurer is authorised to give reasons to on behalf of the life insured. Where the insurer gives reasons to a medical practitioner, the insurer does not also have to give reasons to the insured.[20]

4.2.4 The duty of good faith

Section 13 of the ICA provides that a contract of insurance is a contract based on the utmost good faith. The duty requires each party to a contract of insurance to act towards the other party, in respect of any matter arising under or in relation to the contact, with the utmost good faith.

[18] ICA s 75(4).
[19] ICA s 75(7).
[20] ICA s 75(6).

5 Systemic problems arising from insurers' assessments of mental health symptoms and conditions disclosed during the application process

PIAC is concerned that insurers do not always properly assess the risk posed by individual applicants for insurance who disclose a past or current mental health condition or history. In our experience, it does not appear that decisions to limit or deny cover to an individual applicant because they have disclosed that they have a mental health condition or history are consistently based upon relevant actuarial or statistical data. Commonly, the mere disclosure that a person has a mental health condition or history will lead to an insurer limiting or denying cover, without taking into account factors particular to the individual's condition, including the relative severity or otherwise of the condition, or whether a person is receiving treatment for the condition.

MHA and *beyondblue* share PIAC's concerns about the incomplete and inadequate evidence base being used by insurers in assessing applications involving mental health. PIAC draws the Committee's attention to the research published by the MHA and *beyondblue* in 2011 surveying mental health consumers' experiences in accessing or claiming upon insurance, including life insurance.[21] PIAC endorses the research as reflective of the experiences conveyed to us by our clients.

The survey reports consumers' concerns that broad and often stigmatised assumptions about people with mental illness are being relied upon by insurance companies when assessing applications and claims, instead of, relevantly, their individual and personal circumstances.[22] MHA and *beyondblue* confirm that there is increasing evidence highlighting the unique and diverse experiences of mental illness, the ways in which symptoms manifest and the impact it has on the daily lives of individuals, and that

> …underwriting often fails to fully consider individual circumstances, focusing on the 'illness' rather than fully considering how this fits into the bigger picture of how well a person is functioning in the various aspects of their life on a day to day basis.[23]

5.1 Disclosure of a past or current mental health condition

PIAC has advised and/or represented individuals who have disclosed **a past or current mental health condition** when applying for life insurance, in compliance with their duty of disclosure under the ICA, and the insurer:

a. **refuses** to offer insurance; or
b. offers insurance with a **broad mental health exclusion**, in circumstances where a more limited mental health exclusion would have been reasonable; or

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21 Mental Health Council of Australia and *beyondblue*, *Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011* (2011) available https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0129-report-mental-health-discrimination-and-insurance.pdf?sfvrsn=2

22 The failure of insurers to consider relevant, individual circumstances when applying disability discrimination is also a feature of the general insurance industry: see Financial Rights Legal Centre, *Guilty Until Proven Innocent: Insurance Investigations in Australia* (March 2016) available *http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf*

23 Mental Health Council of Australia and *beyondblue*, above 21, 9.

c. offers insurance without a mental health exclusion but with an **unreasonably high premium**.

PIAC is concerned that insurers appear to be refusing insurance or offering insurance on non-standard terms based on outdated understandings of mental health conditions, which lump unrelated mental health conditions in one category, fail to recognise that mental illness occurs on a spectrum from the very mild to the very serious and can manifest and impact individuals differently depending on the nature and severity of their condition and the individual's particular circumstances.

Through PIAC's casework we have observed instances of insurance providers:

- declining applications for life insurance following disclosure of a mental health history at the application stage. A number of our clients have had applications for insurance declined during a telephone call with the insurer, suggesting to PIAC that some insurers have internal documents that direct their call centre operators to decline an application following disclosure of a mental health issue;
- failing to ask further questions or obtaining further medical information to better understand the applicant's mental health history before deciding the application;
- failing to properly consider the applicant's mental health history and the risk posed to the insurer before deciding the application, for example, by failing to take into account the time that has elapsed since diagnosis or symptoms, the absence of any recurring mental health episodes or hospitalisations, the applicant's compliance with treatment and the applicant's employment history, amongst other things;
- offering a policy with a broad, blanket mental health exclusion that lumps all mental illness together and that is not commensurate with the risk posed by the applicant's medical history.

5.2 Disclosure of a past or current symptoms of a mental health condition

PIAC has also advised and/or represented individuals who have disclosed symptoms of a mental health condition when applying for life insurance but have never been diagnosed with a mental health condition and the insurer:

a. **imputes** a mental health condition that is not supported by the information provided in the application or by medical practitioners; or
b. **refuses** to offer insurance, offers insurance with a broad mental health exclusion or offers insurance with a premium.

PIAC is concerned that some insurers are imputing a mental health condition on the basis of symptoms disclosed during the application process in the absence of a diagnosis from an appropriately qualified medical practitioner and are assessing applications for insurance in reliance on those imputed conditions.

Through PIAC's casework we have observed instances of insurance providers:

- failing to properly consider the applicant's mental health history and the risk posed to the insurer by treating disclosure of minor symptoms of depression and anxiety, for example, feeling 'low' after a relationship breakdown or feeling 'stressed' as a result of work, in the

same category as people who have been diagnosed with moderate to severe depression or anxiety disorders for which they have received ongoing treatment such as counselling and/or medication and/or been hospitalised; and

- offering a policy with a broad mental health exclusion following disclosure of symptoms of a mental health condition in the absence of any diagnosis of a mental health condition.

The establishment of an industry code of conduct would assist insurance providers to improve how they assess applications for insurance where an applicant has disclosed a mental health history and improve outcomes for consumers. Such a code of would facilitate compliance with the ICA and anti-discrimination legislation by requiring life insurance providers to take particular steps in response to applications for insurance, where the applicant discloses a mental health condition.

A life insurance industry code of conduct could be similar to the industry codes that are required to be established for particular industries under Part IVB of the *Competition and Consumer Act 2010* (Cth), and regulated by the Australian Competition & Consumer Commission. The Insurance Council of Australia should be resourced to establish a consultative body to develop and regulate a life insurance industry code of conduct. The consultative body should comprise representatives of the key stakeholders, including life insurance providers, consumers, consumer associations, Federal government and other community groups.

Recommendation 1

PIAC recommends that the Insurance Council of Australia be resourced to establish a consultative body to develop and regulate a life insurance industry code of conduct. The consultative body should comprise representatives of the key stakeholders, including life insurance providers, consumers, consumer associations, Federal government and other community groups.

Recommendation 2

PIAC recommends that the proposed life insurance industry code of conduct should require insurers to:

a. *ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;*
b. *refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;*
c. *give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;*
d. *where an insurer offers insurance on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium), specify:*
    i. *how long it is intended that the exclusion/higher premium will apply to the policy.*
    ii. *the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced.*
    iii. *the process for removing or amending of the exclusion/premium;*
e. *develop, implement and maintain policies that reflect the above practices.*

PIAC welcomes steps that have been taken by the Financial Services Council of Australia (**FSC**) to ensure that insurance companies implement mental health education programs and training for their staff. FSC Standard No 21 came into effect in 2013 and requires financial service providers to obtain annual certification in such training, including the conduct of a review of the effectiveness of the program that states the percentage of representatives who have successfully completed the training.[24]

Recommendation 3

PIAC recommends that the proposed life insurance industry code of conduct include and expand upon the training obligations set out in FSC Standard No 21 and which requires insurers to develop, implement and periodically deliver training to its officers, including call centre operators and underwriters on:

a. *mental health conditions, the spectrum on which they can occur and their treatment;*
b. *the operation and requirements of section 46 of the DDA (the insurance exception); and*
c. *communicating with people with mental illness.*

5.3 Decision-making

5.3.1 Production of statistical or actuarial data & reasons relating to 'other relevant factors'

PIAC has observed instances of insurers declining to offer insurance or offering insurance on non-standard terms to people who disclose a mental health condition at the time of application, and that this action does not appear to satisfy the exception in section 46 of the DDA (set out at paragraph 4.1.2 above).

Currently, the only way to test whether an insurer has satisfied the exception in section 46 of the DDA is for an individual to pursue a legal complaint at a court or tribunal, using compulsory document production processes to access the actuarial and statistical data and other reasons for insurers decisions. This places an unrealistic and unfair burden on vulnerable individuals who suspect an insurer has unlawfully discriminated against them.

Pursuing a legal complaint is arduous, time consuming and expensive. For many of PIAC's clients, the risk of an adverse costs order dissuades them from pursuing a discrimination complaint in the federal courts even when they have a strong claim. It is not unusual for respondent insurers to retain large law firms and senior and junior counsel to represent them and costs, even on a party/party basis, can be significant. Due to the risk of an adverse costs order, many strong discrimination complaints settle on terms that may be favourable to the claimant but are far less than they ought to be under the law. Most often respondent insurers insist that any such settlement be confidential and insurers do not admit liability. The result is that the impetus for making any long-lasting change to current practice is lost and no legal precedent is made.

It is not known what, if any, actuarial and statistical data insurance companies rely on to assess the insurance risks of people experiencing mental illness. In PIAC's experience, insurers protect this information on the basis of it being commercial in confidence. Where we have been provided

[24] Financial Services Council Standard No. 21, *Mental Health Education Program and Training* (22 August 2013) http://www.fsc.org.au/downloads/file/FSCStandards/21SMentalHealthEducationProgramandTrainingStandardFINAL22August2013.pdf.

access to data, that data is generally in the form of often-general medical literature, which is not always up-to-date or relevant to the insured's particular circumstances.

The current lack of a specific requirement for insurers to make the material that they rely on available to consumers means that the statistical and actuarial data is rarely provided. It is extremely difficult for consumers to gain access to the data relied upon by insurers in decisions that affect them. If an applicant has applied for insurance through an insurance broker, the insurer will generally decline to communicate with the applicant directly. This lack of transparency can at times operate to reinforce discrimination against people with mental illness and limits the ability of applicants to seek review of an insurer's decision to decline an application or to offer insurance on non-standard terms.

PIAC submits that insurers who purport to rely on the exception in section 46 of the DDA should be required by the DDA to provide copies of the actual actuarial and statistical data relied on without the insured needing to first lodge a formal legal complaint. Where copies of the actuarial or statistical data are unable to be provided because the material is considered to be commercial-in-confidence, the insurer should be required to provide a detailed summary that specifies the type of data the insurer has relied on, and the relevance of that data to the decision to decline insurance coverage to the applicant, or to offer coverage on non-standard terms.

Where copies of the actuarial or statistical data relied on are provided by the insurance company to an individual, the data should be accompanied by a plain-English summary of that material in a readily accessible format, which should make reference to the evidence of the specific additional risk that the applicant represents. Information provided to consumers by insurance companies should also include information on what steps the applicant may take if they are not satisfied with the decision.

PIAC notes that provisions reflecting this recommendation were included by the Australian Government in the Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012.[25]

Recommendation 4

That section 46 of the DDA be amended to:

a. *require insurers to provide copies of the actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer within a reasonable time frame upon request. Wherever possible, this material should be provided to the applicant with a summary in a readily accessible and plain-language format, making reference to the specific additional risk that the applicant represents;*
b. *require insurers to provide a detailed summary that specifies the type of data that the insurer has relied on, and the relevance of that data to the decision to decline insurance coverage to the applicant, or to offer coverage on non-standard terms, where copies of the actual actuarial and statistical data relied on are not able to be provided because the material is considered to be commercial-in-confidence;*
c. *require an insurer to advise a consumer what relevant factors it considered, why it considers each of those factors to be relevant, and how those factors affected its decision in relation to an offer of insurance;*

[25] See Exposure Draft Human Rights and Anti-Discrimination Bill 2012 subs 39(5)(a)(i) available http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Completed_inquiries/2010-13/antidiscrimination2012/info/index

d. *specify that 'other relevant factors' (consistent with the Australian Human Rights Commission guidelines and the decision of the Federal Court in Bassanelli):*
    i. *means all other relevant factors, and not just the factors selected for consideration by the particular insurer or other person seeking to invoke the exemption. This includes factors that reduce any risk to insurers as well as the factors that increase the risk to insurers;*
    ii. *includes the factors that are relevant to the circumstances of the individual applicant; and*
    iii. *is not exhaustive and that any other factors not listed in the DDA or AHRC guidelines may be considered relevant.*

5.3.2 Providing written reasons and internal reviews

Where an insurance provider has declined to offer insurance or has offered insurance on non-standard terms, the applicant (on written request) is able to obtain written reasons for the decision and seek an internal review of the insurer's decision.

There a no time periods built into the ICA in relation to the time for considering and deciding an insurance application, or for undertaking an internal review of a decision on whether or not to grant insurance.

In PIAC's experience:

- insurers will only provide written reasons after multiple requests and when the request for reasons is in writing (as currently required by the ICA) and even then the explanation may be put in terms that do not assist the applicant to understand the particular issue for the insurer, for example, 'based on your medical history';
  it can take up to six months, and sometimes longer, for an insurer to review an application for internal review on a decision;
- where an applicant for insurance has applied for insurance through an insurance broker, the insurer will only communicate with the insurance broker, thereby reducing the applicant's ability to advocate for themselves and relying on the efficacy and expertise of the insurance broker who often has only a basic understanding of mental illness;
- insurers will often ask for medical health records spanning most or all of the applicant's life as part of the internal review process. This can be time consuming and costly for an applicant for insurance. In addition, insurers often ask for these records some time into the review process (for example one to three months), which has the effect of significantly delaying the review process and the period of time for which the individual remains uninsured;
  the result of the internal review is almost always to reaffirm the original decision;
- the prospect of obtaining an improved outcome following internal review increases dramatically where an applicant has engaged legal representatives, sometimes at additional cost to the applicant.

Recommendation 5

Section 75 of the ICA should be amended to require:

a. *insurers to provide written reasons when asked by an insured, irrespective of whether the insured has made the request orally or in writing, or alternatively require insurers to state in the letter declining cover that under section 75 of the ICA an insurer must provide written reasons upon written request given to the insurer;*
b. *the written reasons provided by the insurer to explain the actuarial or statistical data that they have relied upon to decline cover to the applicant. The data cited and relied upon must address the specific disclosures made by the applicant.*

Recommendation 6

The ICA should be amended to require insurers, within 14 days of receiving an application for review in relation to a decision not to provide insurance, to offer insurance on non-standard terms, or to avoid a policy for 'non-disclosure', to specify which documents they require to conduct the review, and to require that the documents sought are relevant to the decision/review.

Recommendation 7

PIAC recommends that the proposed insurance industry code of conduct requires insurers to:

a. *provide information and undertake internal reviews within reasonable time periods.*
b. *correspond directly with an applicant or insured who made their application for insurance through an insurance broker wherever the applicant or insured so wishes.*

6 Systemic problems arising from insurers' avoidance of policies for alleged non-disclosure of a mental health condition or symptoms of a mental health condition

PIAC has advised and/or represented individuals who have had their life insurance policies avoided (cancelled from commencement) by insurers for their purported failure to comply with their duty of disclosure at the time they applied for cover or to amend existing cover, in circumstances where the non-compliance is innocent, or where the insured did not know, and could not reasonably have known, that their prior medical interactions would have been relevant to an insurer's decision to offer a policy.

PIAC is concerned that insurers appear to be unfairly and unnecessarily avoiding insurance policies to avoid paying legitimate, reasonable claims. PIAC is of the view that in some circumstances this practice constitutes a breach of the duty of good faith as required by section 13 of the ICA.

6.1 Alleged breaches of the duty of disclosure

In PIAC's experience, an allegation by an insurer that the insured has not complied with their duty of disclosure generally arises after the insured has made a claim for a benefit against the policy. Often the claim that the insured is making against the policy is not related to mental health.

After an insured has made a claim against their policy, the insurer obtains access to and reviews the insured's medical records. PIAC has seen instances of insurers obtaining an insured's complete medical history, including from doctors that treated the insured during childhood, before deciding a claim.

PIAC has found that insurers often rely on matters 'discovered' during the review of the insured's medical records to allege that the insured has breached their duty of disclosure.

Often the conclusions drawn by the insurer from the insured's medical record about their experiences of mental health are inconsistent with the insured's medical record and the opinions of their treating medical practitioners.

For example, PIAC has represented clients where the insurer has alleged there has been a breach of the duty of disclosure because:

- notes taken by a psychologist during a consultation with the insured show the psychologist suspected the insured might be depressed, despite the psychologist confirming to the insurer that he had never made a diagnosis of depression nor communicated his concerns that the insured was depressed to the insured;
- the treating medical practitioner retrospective diagnosed a mental health condition – ie, the practitioner did not make this diagnosis at the time of treatment nor communicate it to the insured;

- the insured interpreted an accidental overdose of pain medication to be a suicide attempt despite medical evidence from the insured's treating medical practitioners, including contemporaneous medical evidence, confirming the overdose was accidental;
- the insured sought counselling from a psychologist following the breakdown of a relationship, in circumstances where there was no diagnosis of a mental health condition.

6.2 Avoidance for breach of the duty of disclosure

PIAC has represented individuals who have had a policy avoided because the insurer has relied on medical records to impute a medical condition that either did not exist or that the insured did not know existed at the time of applying for insurance.

In PIAC's experience, it appears that consumers are being disadvantaged by the reforms to the remedies available to insurers (as set out at paragraph 4.2.2 above), or at the very least, are not seeing any benefits flowing from the increased flexibility.

Take the following example, which has been anonymised and adapted from PIAC's casework experience:

The insured obtained income protection insurance. During the application process, the insured did not disclose that he had seen a counsellor three years prior, initially to discuss the breakdown of his marriage and then, seeing that the counselling had been effective, undertaking further counselling to discuss issues he had experienced historically with his family. Two and a half years after obtaining insurance, the insured was diagnosed with prostate cancer and stopped working. He made a claim on his income protection policy. The insurer initially paid the claim but, after obtaining the insured's medical records and discovering the appointments with the counsellor, the insurer argued that the insured had not complied with his duty of disclosure when answering the question: 'Have you ever been diagnosed with or ever had symptoms of any mental health disorder?'. The insured argued that he had never been diagnosed with a mental health condition or had symptoms of a mental health condition and answered the questions asked of him during the application process truthfully. The insurer relied on clinical notes that described observations by the treating doctor that the insured had been feeling low and that they had discussed anti-depressant medication. The insurer avoided the policy for innocent non-disclosure. In addition to ceasing to pay the claim, the insurer threatened to take steps to recover the amount of benefits that had already been paid.

Scenario A – if the policy for insurance commenced prior to 28 June 2014 when the changes came into effect. The insured is able to prove that, according to the insurer's underwriting guidelines, the insurer would have offered him income protection insurance with a mental health exclusion. Because the insurer would have offered 'a' policy of insurance, the insurer is not entitled to avoid the insured's policy and must continue to pay the insured's unrelated claim arising from his diagnosis with prostate cancer.

Scenario B – if the policy for insurance commenced after 28 June 2014. The insured is unable to prove that the insurer would have offered him the same policy had he made the alleged non-disclosure during the application process. The insurer is entitled to avoid the policy and the insured's claim is not paid.

As the above scenarios demonstrate, decisions to avoid contracts of insurance can operate harshly on people who reasonably believe that they are protected by insurance. In most of the cases PIAC has been involved with where the insurer has alleged that the insured did not comply with their duty of disclosure, the insurer has elected to avoid the insured's policy or policies. Avoidance often occurs at a point in time where the insured is particularly vulnerable and has made a claim on the policy (often for a condition that is not related to mental health), thereby depriving them of the benefit of the insurance.

However, there are other, less drastic measures that an insurer may take under the ICA. Insurers are able to vary a contract of insurance *at any time*, whether the non-disclosure is fraudulent or non-fraudulent, to adjust the sum insured using a statutory formula for proportionality,[26] or to vary the terms of the contract to place the insurer in the position they would have been in if the duty of disclosure had been complied with.[27]

The discretion as to whether to vary or to avoid a contract of insurance rests solely with insurers. PIAC is not aware of any industry standards or best practice guidelines to assist insurers to reach fair and reasonable decisions about when to choose to vary and when to choose to cancel.

The unfairness of avoidance is particularly evident where the insurer purports to avoid a policy of insurance for non-disclosure of matters that were known to the insurer, or could reasonably have been known to an insurer, from medical information provided about the insured in respect of prior applications for insurance with the same insurer that was accepted by the insurer.

Through PIAC's casework we have observed instances of insurance providers:

- imputing a mental health condition where there was no diagnosis of a mental illness from medical professionals and the existence of a condition is otherwise not supported by the medical evidence. For example, we have seen insurers rely on clinical records that show a GP discussed taking anti-depressant medication with the insured as evidence that the insured had depression;
- forming conclusions about the insured's experience of symptoms of mental illness in a manner that was inconsistent with the opinions of the medical professionals treating the insured. PIAC has seen examples of insurers failing to accept and/or failing to take into account the evidence of a treating medical practitioner about the absence of diagnosis or the low severity of a condition;
- taking an approach that penalises and discourages people from seeking preventative, early medical assistance to manage 'normal' reactions to common life situations well in advance of any diagnosis of mental illness, which undermines government-funded campaigns and programs that encourage help-seeking.

Recommendation 8

Parliament should reverse the amendments to section 29 of the ICA. That provision should require an insured to prove that the insurer would have offered the insured 'a' contract of insurance not 'the' specific contract of insurance that is the subject of dispute.

[26] ICA s 29(4).
[27] ICA s 29(6).

Recommendation 9

The proposed life insurance industry code of conduct should:

a. *require insurers to vary rather than avoid policies wherever reasonably possible;*
b. *include guidance notes providing examples of situations in which variation rather than avoidance of a policy is appropriate, including where the insured has made a claim on their policy for an illness or condition that is unrelated to the illness or condition that it is alleged was required to have been disclosed during the application process.*

Recommendation 10

Each insurer should be required to report publicly (eg, in its annual report) the number of policies that it avoided in the previous 12 months.

7 Improving oversight of insurer compliance with anti-discrimination law

PIAC submits that there is insufficient oversight of the decisions of insurance providers. The current regulatory framework does not contain provisions to regulate compliance of insurance providers with anti-discrimination law. Insurance providers are not required to disclose the actuarial or statistical data that they have relied upon, or other relevant factors, to make a decision in response to an application for cover.

This can cause consumers to be confused about why their application for insurance has been declined. It can also foster discrimination because it is not apparent that the decision was reasonable having regard to actuarial and statistical data on which it is reasonable for the insurer to rely, or having regard to all other relevant factors. It can also make it difficult for consumers to seek review of a decision of an insurance provider, as they do not have access to the information on which the decision was based.

In this part, PIAC proposes solutions for more effective oversight aimed at requiring insurers to report, and be audited, on decisions to discriminate. Also, PIAC proposes to reduce costs barriers to individuals commencing litigation to enforce insurer compliance with anti-discrimination law.

7.1 Reporting decisions to discriminate

To enhance accountability in relation to the operation of section 46 of the DDA, insurers should be required to report annually to the Australian Human Rights Commission (**AHRC**) instances of reliance on the insurance exception to refuse or to offer insurance products on non-standard terms, specifying the category of disability invoked by the exception, and stating whether the insurer has relied on actuarial and statistical data to reach their decision. Where no actuarial or statistical data exists that is reasonable for the insurance provider to rely on, the provider should set out the other relevant factors on which their decisions have been based, in order to satisfy the section 46 exception of the DDA. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.

This approach would ensure that consumers, the insurance sector and the AHRC (or another statutory agency) are all able to monitor the extent to which insurance products are able to accommodate people with disabilities on an equal basis and how the exception is being used over time. It may also enhance the quality of decision-making, focusing on the requirement that decisions be evidence based.

When a claim of unlawful discrimination against an insurance provider is before the AHRC or state anti-discrimination body, and the complaint concerns the exception for insurance providers, insurance providers should be required proactively to provide the actuarial and statistical data, and/or all other relevant information, relied upon to support the decision that is alleged to be discriminatory.

The AHRC or another statutory agency should be empowered to investigate and enforce breaches of the DDA, including the power to audit an insurer's actuarial and statistical data when appropriate to do so.

If the Committee does not adopt the above accountability mechanisms, PIAC submits that at the very least, the Australian Government should negotiate an agreement with insurers requiring the publication of data upon which decisions about insurance offerings based on disability are made. PIAC notes that a similar recommendation was made by the Australian Law Reform Commission (**ALRC**) with respect to insurance offerings based on age, the ALRC having referred to an existing such agreement between insurers and the UK government.[28]

Recommendation 11

a. *Insurance companies should be required to report annually to the Australian Human Rights Commission the number of times they have declined to provide insurance or offered insurance on different terms on the ground of disability. This information should specify whether the insurer has relied on actuarial and statistical data in making their decision and the category of disability invoked by the exception. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.*
b. *When a matter is before the AHRC or state anti-discrimination body, insurers should be required to promptly provide to the AHRC or state anti-discrimination body the actuarial and statistical data and other relevant factors relied upon to decline coverage or refuse a claim on the ground of mental illness or another protected attribute, when requested to do so.*
c. *Insurers should be required to comply with updated insurance Industry Anti-Discrimination Guidelines that could be developed by the AHRC.*
d. *The AHRC or another statutory agency should be empowered to investigate and enforce breaches of the DDA, including the power to audit an insurer's actuarial and statistical data.*
e. *At the very least, the Australian Government should negotiate an agreement with insurers to require them to publish data on which decisions about insurance offerings based on disability are made.*

[28] Australian Human Rights Commission, *Access All Ages – Older Workers and Commonwealth Laws*, ALRC Report 120 (30 May 2013) [6.28] – [6.37]; Recommendation 6-2, available http://www.alrc.gov.au/publications/access-all-ages-report120/6-insurance

8 Clarifying the complaints process

Individuals that have had their contract avoided, application for insurance denied or accepted on non-standard terms, or a claim denied because of their disability may have claims under both the ICA and the DDA (or state anti-discrimination legislation).

For claims under the ICA, a complaint must be lodged with the Financial Ombudsman's Service (**FOS**). FOS provides dispute resolution services between consumers and financial service providers. FOS's Terms of Reference state that in relation to general insurance disputes, an applicant has two years to bring a complaint with FOS – taken from the date of receiving a final response on internal review from an insurance service provider. If no final response resulting from internal review has been provided, an applicant has six years from the date when the applicant first became aware, or 'should reasonably have become aware', they suffered the loss to lodge a complaint with FOS. In PIAC's experience, once a complaint is lodged with FOS it can take between approximately one to two years before the complaint is resolved.

Where the conduct of the insurer constitutes unlawful discrimination in breach of the DDA or state anti-discrimination legislation, an individual will have one year from the date on which the unlawful discrimination occurred to lodge a complaint with either the AHRC or state anti-discrimination body (eg, the Anti-Discrimination Board in New South Wales, or the Victorian Equal Opportunity & Human Rights Commission). In our experience, once a complaint is lodged with the AHRC or state anti-discrimination body it will take approximately six months before the complaint is resolved.

FOS's Terms of Reference provide that FOS may decline to consider a dispute that has already been dealt with by a court or dispute resolution tribunal established by legislation, or that has already been lodged with, and is being dealt with, another external dispute resolution scheme approved by ASIC. Similarly s 20(2) of the *Australian Human Rights Commission Act 1986* (Cth) provides that the AHRC may decide not to inquire into a complaint, or may decide not to continue to inquire into a complaint if the AHRC is of the opinion that a more appropriate remedy in relation to the subject matter of the complaint is reasonably available to a complainant (s 20(c)(v)), or that the complaint could be more effectively or conveniently dealt with by another statutory authority (s 20(c)(vi)).

In PIAC's experience, the above Guidelines and legislation require a person who has a valid claim under both the ICA and anti-discrimination legislation to elect which jurisdiction to commence a complaint in. The choice made by the complainant may impact the remedies that are available to the complainant by:

a. preventing them from commencing a complaint in another jurisdiction if the complaint in the jurisdiction initially elected is unsuccessful; and
b. operation of the various time limits – eg, if the period taken to resolve the complaint in the initial jurisdiction is such that the individual finds that they are then outside of the time limits within which to bring a complaint in the other jurisdiction.

Determining the appropriate jurisdiction within which to commence a complaint can be difficult and complex, and an individual will often require legal advice regarding the merits of their claims in each jurisdiction, and on procedural matters relating to choice of jurisdiction.

Recommendation 12

When a complaint is lodged with either FOS, the AHRC or a state anti-discrimination body, and the complaint concerns:

a. *an insurance contact that has been avoided;*
b. *application for insurance denied or accepted on non-standard terms; or*
c. *an insurance claim that has been denied because of a person's disability,*

that FOS, the AHRC or state anti-discrimination body be required to advise the complainant to seek legal advice on choice of jurisdiction and the merits of their matter before the complaint is accepted for conciliation. If the complainant is unable to obtain legal advice then FOS, the AHRC or state anti-discrimination body should provide the complainant with information regarding choice of jurisdiction before the complaint is accepted for conciliation.